Providing Medications at Release: Connecticut and Rhode Island

Medicaid Areas of Flexibility to Provide Coverage and Care to Justice-Involved Populations

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Medicaid and the Justice-Involved Population

States have flexibility in deciding who will be covered under their Medicaid program within established federal guidelines. Many states have increased the number of justice-involved individuals covered by Medicaid by expanding eligibility to low-income adults. Medicaid cannot pay for medical services provided to persons while they are incarcerated, except when in-patient services are provided in a community based hospital setting. However, many other people involved in the justice system—from arrest through community-based supervision—are eligible to receive Medicaid benefits when they are not incarcerated, if they are income eligible and meet certain other criteria. Providing health care services to people involved with the justice system could improve public health and public safety, given their high prevalence of mental health issues, substance abuse, and chronic health conditions including HIV and hepatitis. This series of briefs highlights areas of flexibility within Medicaid that can facilitate enrollment in health coverage and access to necessary care in the community for justice-involved people.

Providing people with medically necessary prescription medication when they are released from incarceration is one way to promote public health and public safety, given the high prevalence of significant medical and mental health issues among people in prisons and jails across the country.[1] Connecticut and Rhode Island have established practices to ensure continuous access to medication for justice-involved people. Under Connecticut's Medicaid Prescription Voucher program, the state's Medicaid agency pays for up to a thirty-day supply of medication dispensed within five days of release from incarceration for people who applied for Medicaid before their release. For Medicaid-eligible individuals in Rhode Island, Medicaid covers the cost of filling prescriptions written by corrections

medical staff upon release as well as the cost of medications filled after an inmate is transported to an opioid treatment program health home after release from incarceration.

The initiatives highlighted here address challenges that include ensuring access to needed medication for people who are eligible but not yet enrolled in Medicaid, and unpredictable release dates, which are particularly common for the jail population. Because the Connecticut Department of Correction and the Rhode Island Department of Corrections operate unified corrections systems that house pretrial detainees and other jail-based populations, as well as convicted people serving prison sentences, the prescription drug programs discussed in this brief cover both jail and prison populations.

This brief is based on interviews with key individuals involved in the initiatives in Connecticut and Rhode Island that aim to use Medicaid to cover the costs of medication at release from incarceration, published materials accessible to the public at large, and documents provided to us by interviewees. It summarizes the progress in each state to provide medications at release from incarceration, as well as challenges that have been encountered and—in some cases—remedied. It also highlights lessons that may be helpful to other states interested in launching similar initiatives.

Connecticut's Medicaid Prescription Voucher Program

Since the 1970s, the Connecticut Department of Correction (CDOC) has run programs focused on treatment and reentry for people being released from state correctional facilities (CDOC 2014). Since at least 2001, Connecticut has typically provided up to 30 days' worth of medically necessary prescription medication when people are released[2] from jail or prison—when this release is on schedule or nearly on schedule.[3] However, in the mid-2000s, state officials realized that they had no reliable way of providing medication to people who were released unexpectedly—for example, as a result of pretrial release by the court or a parole decision (Trestman and Aseltine 2014). The state developed the Medicaid Prescription Voucher program to provide needed medications upon release even to individuals leaving correctional facilities unexpectedly, and has made significant revisions to the program since it was first piloted in 2010.

Longstanding efforts to facilitate continuity of care for individuals exiting incarceration in Connecticut laid the foundation for the state's Medicaid Prescription Voucher program. Since 2002, the CDOC has had memoranda of understanding with the Department of Social Services (DSS), the state Medicaid agency, related to Medicaid prerelease services. To better and more reliably support people with significant medical and mental health needs during their transition back to the community, in 2007 Connecticut formed an interagency committee coordinated by the Office of Policy and Management—comprising staff from CDOC, DSS, parole, the Department of Mental Health and Addiction Services (DMHAS), and the courts (Trestman and Aseltine 2014). In the same year, Correctional Managed Health Care (CMHC), which provided inmate medical services, formed a collaboration with DMHAS, Yale University's Schools of Medicine and Nursing, and the Yale New Haven Hospital to train clinicians as discharge planners (Trestman and Aseltine 2014). These discharge planners (generally nurses and social workers) were then deployed throughout state correctional facilities to help inmates complete

Medicaid applications, and—later—to schedule appointments on behalf of inmates. This effort began with a focus on inmates with significant medical or mental health needs, but discharge planners ultimately made themselves available to all inmates returning to the community.

In December 2010, the Medicaid Prescription Voucher program was piloted at two correctional facilities—York Correctional Institution and the Willard-Cybulski Correctional Institution—and the New Haven, Waterbury, and Middletown courts. This program later expanded in 2012 to include two new correctional facilities and several additional courts.[4] As of September 2016, all CDOC facilities in Connecticut have implemented the Medicaid Prescription Voucher program.

During the 2010–12 rollout, increased collaboration across state agencies illustrated the need to synchronize processes. By 2011, it was clear to state officials that the use of multiple, discordant release-of-information forms had resulted in "inefficient, delayed, or inappropriate care and [exposure of] the patient to significant risk" when health information needed to be exchanged across agencies. To increase efficiency, a number of Connecticut agencies—including the CDOC, the Department of Children and Families, DMHAS, the Board of Pardons and Paroles, CMHC, and the judicial branch—agreed to accept each other's forms.[5]

When Connecticut decided to expand Medicaid to low-income adults, it also changed policies significantly to establish the processes necessary for the voucher program. According to a 2014 article in *Perspectives in Health Information Management*, the DSS Pre-Release Entitlement Unit was "reorganized to support an expedited Medicaid application process" (Trestman and Aseltine 2014, 1e). The state maintains enrollees' active Medicaid status through 60 days of incarceration and places them in suspension status after 60 days (Ryan et al. 2016). Connecticut also reinstates Medicaid status for those who had been in a suspension status when they are released. As explained by a state informant, by "virtually suspending"—rather than terminating—Medicaid benefits, Connecticut significantly reduces future administrative burden and ensures swifter access to Medicaid services at release.

Through the Medicaid Prescription Voucher program, people leaving prison or jail are issued vouchers when a licensed prescriber from CMHC has prescribed a medication. According to one informant at the CDOC:

> The voucher, today, is filled out in conjunction with what we call a Discharge Planner (who could be a social worker or a nurse). The voucher is basically an added page to an application (rather than a prescription). When we know someone is on medication and has the potential to leave the facility quickly, and when that Medicaid application is filled out, sometimes that voucher gets attached to it for these fast and quick-moving populations. They get filled out and handed to the inmate. And the application that goes up has a cover sheet to Medicaid that says the voucher was filled out, so they know.

Each voucher—which is valid for 5 days after its authorization date—guarantees payment by the DSS for up to a 30-day supply of prescription medications even if an individual is subsequently determined ineligible for Medicaid (Trestman and Aseltine 2014). According to state officials, the state pays for the cost of the medications if someone is determined ineligible for Medicaid, but virtually all applicants who receive the voucher are determined eligible. Because of the Pre-Release Entitlement

Unit created to expedite applications for people about to be released from incarceration, those determinations are usually effective at the time of their release. The person need only present the voucher at any community pharmacy that routinely accepts Medicaid, at which point "the discharge prescription is requested by the community pharmacy by faxing the front of the voucher" to the CMHC pharmacy at the University of Connecticut's John Dempsey Hospital—the facility primarily responsible for inpatient and outpatient care under the CMHC contract (Trestman and Aseltine 2014).[6] That is, the community pharmacy faxes the voucher to the CMHC pharmacy. This fax sets into motion a process that culminates in a CMHC pharmacist contacting the on-call physician, who provides the CMHC pharmacy with discharge orders. The community pharmacy then receives verification from the CMHC pharmacy and is then able to fill the discharge medication prescription. In all, obtaining a discharge medication prescription from a physician takes anywhere from under an hour to a full business day (Trestman and Aseltine 2014).

The *Perspectives in Health Information Management* article, which was informed by interviews with Connecticut state officials, describes the process for activation (or reactivation) of Medicaid benefits upon release as follows: "For most releases directly from a correctional facility, staff at the facility have already notified DSS and arranged for medical benefits to be activated. For releases from court, which are generally unscheduled, the court staff faxes an application for benefits to DSS, and DSS is prepared to activate those benefits very quickly. […] If Medicaid eligibility is not confirmable through the DSS Automated Eligibility Verification System within five days, a backup paper method is also in place" (Trestman and Aseltine 2014, e1).

The fact that we're able to get Medicaid eligibility in place very quickly for this population really doesn't add much administrative burden on our hand. Pharmacists are just able to use the regular claims filing system to get paid.
—Connecticut Department of Social Services official

Though the voucher program has been implemented statewide, several operational challenges persist. Multiple sources report that smaller independent pharmacies sometimes question the validity of vouchers or refuse to accept vouchers because of the paperwork involved in the reimbursement process. In the words of a CDOC informant:

> [Pharmacies] have to then use a paper system to get reimbursed. Even though policy directives have been sent out from the Medicaid agency to the pharmacies a number of times, they don't want to do it. So, many folks have been denied at the pharmacies. And this is where MOUs and contracts that we have in place with our Medicaid agency are important. They're on call, and will handle the pharmacies. They'll say to the pharmacy: "You can't deny them. This is a promissory

> note to pay." [Pharmacies] don't want to fill out the paperwork. That's been a long haul, and we're getting better with it. But this still happens.

A lack of electronic automation also hinders the voucher program's effectiveness; DSS's Automated Eligibility Verification System, which determines Medicaid eligibility, is the only automated system in place. CMHC does not have an electronic health record or electronic processes for medication dispensing related to the voucher program, so there are no automated ways to transmit a discharge order or a prescription from an on-call physician to a community pharmacy processing a voucher. All steps in the process must be completed manually. Interviewees acknowledge that increased automation would improve the program's outcomes, both on the front and back ends.

Additionally, even when a system is in place, ensuring that individuals fill their medication prescriptions when they are released to the community remains a challenge, but interviewees believe that the share of discharge prescriptions filled has increased over time. According to one report released in 2014, "40 to 60 percent of all discharge prescriptions in the voucher program [were] filled" (Trestman and Aseltine 2014, e1).

Rhode Island Initiatives to Provide Medicaid-Funded Medications at Release

Rhode Island also expanded Medicaid coverage to low-income adults. For those eligible, including a large share of the justice-involved population, enrollment in risk-based managed care is mandatory, and enrollees select from two managed care plans: one nonprofit and one for-profit. The state helps people leaving correctional facilities apply for Medicaid and plan for care after release. When returning to the community, each person is assigned a discharge planner, who is dually responsible for helping individuals apply for Medicaid and driving discharge planning efforts aimed at ensuring continuity of care (e.g., by arranging medications at release). Because Rhode Island is a small state, respondents reported that coordination across government agencies may be easier than in larger states; in addition, the Department of Corrections (DOC) and the Department of Human Services (which administers Medicaid) have a strong working relationship. With only 300 people released per month on average, corrections agencies are able to manually look people up in the Medicaid enrollment database to determine enrollment status. About one-third of inmates released are on Medicaid at the time of release. Rhode Island has also implemented health homes for Medicaid enrollees with chronic conditions as a state option under the Affordable Care Act.

Rhode Island DOC ensures pharmacological continuity upon an individual's release from prison through several initiatives and processes. For individuals with a psychiatric condition being treated by medication, the DOC provides a short-term supply of medication upon release.[7] Medicaid funding for medications provided upon release is made possible through three initiatives: Rhode Island's Medicaid Healthcare Portal, the opioid treatment program (OTP) health home, and the Medicaid managed care Vivitrol pilot program.

Prescriptions to Be Filled through the Medicaid Healthcare Portal after Release

Before release, inmates can initiate a request for a prescription from the DOC either informally or as part of the formal discharge planning process (in which case a discharge planner uses a form to request prescriptions). However, it is a challenge to ensure that all inmates who need to request a prescription actually do so. Often, a discharge planner or DOC physician follows up and makes sure the prescription has been written.

Prescriptions provided by the Rhode Island DOC upon release can be taken immediately to a pharmacy. The cost of said prescription is covered by Medicaid if the individual is enrolled and the prescription is a covered benefit. If an inmate is enrolled in Medicaid at release, this enrollment information is available to pharmacies via the state's Medicaid Healthcare Portal. The pharmacy fills initial prescriptions on a fee-for-service basis until a managed care plan assignment is identified in the Portal.

We piloted a program where everyone was given a prescription. We ran into a problem where inmates didn't pick it up because they couldn't pay. That was prior to Medicaid expansion, but we haven't revisited it since.
—Rhode Island Department of Corrections official

Though Medicaid eligibility information can be accessed through the Healthcare Portal, prescriptions written at the DOC are not available electronically in that system and have to be faxed or transmitted via hard copy. Specifically, prescriptions written while someone is incarcerated are filed electronically with Contract Pharmacy Services, an out-of-state pharmacy. However, Rhode Island pharmacies that use SureScripts or AllScripts (which do not interface with Contract Pharmacy Services) cannot access prescriptions written within the DOC. Moreover, the DOC cannot access the Healthcare Portal, though it is currently in negotiations to gain access. If these negotiations are successful, Rhode Island pharmacies could access DOC prescriptions through the Healthcare Portal that would interface directly with the DOC's electronic health record.

Immediate Postrelease Access to Medications at a Medicaid-Funded Opioid Treatment Program Health Home for Those Receiving Medication-Assisted Treatment

Complex patients such as those receiving medication-assisted treatment (MAT) may go through more intensive medical discharge planning and are connected with a provider in the community. Access to MAT upon release has been established through Rhode Island's OTP health home initiative. The OTP health homes were developed to serve opioid-dependent Medicaid recipients who are receiving or who

meet criteria for MAT. As part of discharge planning, discharge planners facilitate Medicaid enrollment for inmates before release and discuss health homes and the services available. If an inmate is interested in methadone treatment and is going to an OTP health home, the discharge planner notifies the OTP, which sends staff to do in-reach and determine program eligibility. Additional preliminary intake work takes place 30 days before the individual is released. Upon release, the individual is a client of the OTP and can receive services *immediately* from the health home provider. Health home initiatives interacting with justice-involved populations are discussed in detail in a separate brief in this series, "Connecting Justice-Involved Individuals with Health Homes at Reentry: New York and Rhode Island."

Pilot Program to Provide Naltrexone under Medicaid Managed Care upon Release

Rhode Island's DOC and Medicaid program were offered an opportunity to offer MAT upon release through a subsidized pilot program, which was funded by the US Department of Health and Human Services' National Institutes of Health with support from the manufacturer of Vivitrol. Vivitrol is an extended-release injectable naltrexone whose medical indications include the prevention of opioid use disorder relapse (with or without co-occurring alcohol use disorder). To operationalize this pilot program, Rhode Island's DOC and Medicaid program had to have their two managed care providers agree to amend their contracts in order to address medications at release. Coordinating with the Office of Medicaid, the DOC sent a letter to the providers requesting a change to the preauthorization requirements for Vivitrol for a specific population on release from the DOC and explaining the exceptional circumstances. In addition, Rhode Island's DOC signed a memorandum of understanding with community providers to ensure that follow-up counseling and injections were available to program participants after discharge.

Starting when the pilot began in March 2012, the Rhode Island DOC identified people who were appropriate for the Vivitrol pilot through existing substance use disorder treatment programs. The people selected received two individual counseling sessions to measure their motivation for change and to assess whether Vivitrol was an appropriate treatment. After that, DOC's medical team assessed whether the pilot program was a good fit and tested liver function. The DOC monitored the administration of a low dose of Vivitrol to eligible program participants for several days to ensure no allergic reactions. Between a week and two days before release, participants were given a Vivitrol injection; once released from jail or prison, they underwent a "strong handoff to a community program" that provided a follow-up Vivitrol injection 28 days after the first injection. A program assessment for this pilot is under way to determine whether the monthly injection of naltrexone is "practical and useful in the prevention of relapse to opioids and re-incarceration" when MAT is initiated before people are released from prison.[8] Findings from the pilot are not yet available.

Lessons Learned

Both Connecticut and Rhode Island are working to ensure people leaving incarceration are provided with needed prescription medications at release, and each state has developed systems to cover at least

some of these medications through its Medicaid program. The following lessons include both successful approaches and remaining challenges and might be useful to other states considering similar initiatives.

- **Knowledgeable interagency committees were key to successful implementation.** In both states, the interagency committees that focused on improving jail and prison reentry outcomes had a sound understanding of the gaps in services and possible remedies. In addition, these collaborating partners often played an important role in implementing the new initiatives.
- **Relationships were leveraged to expand access to medication upon release from incarceration.** Partnerships between correctional agencies and health care providers—such as the new OTP health homes that could treat newly Medicaid-eligible adults after release—laid the groundwork for services targeting individuals returning home.
- **Connecticut's history of coordination among the Medicaid program, the Department of Mental Health and Addiction Services, and court support staff was a necessary component.** Well-established relationships with court support service staff helped facilitate access to medication for people released from correctional custody after a court hearing.
- **A strong discharge planning process was critical to success.** In both Connecticut and Rhode Island, the discharge planning systems assessed needs and provided "discharge prescriptions," as well as access to other services, when necessary. Discharge planners also assisted with Medicaid applications and, in some cases, helped individuals connect with additional support services or specific medical providers.
- **Being able to work with prisons and jails simultaneously helped develop a more comprehensive approach.** Unified corrections systems—such as those operating in Connecticut and Rhode Island—enabled state practitioners to establish procedures for ensuring medication continuity for all individuals exiting incarceration. States that do not have unified corrections systems may need to consider alternative strategies in order to provide individuals returning home from prisons or jails with the medications they need. Since people in jail can be released by the court quickly and with short notice, ensuring medication continuity for them proves far more difficult.
- **Technological limitations affected both continuity of care and system efficiencies.** Interviewees in Connecticut noted that the lack of interoperability of the patient's electronic health record among health care providers within and outside the DOC was a barrier to maintaining continuity of medication for patients moving in and out of incarceration. Similarly, a lack of automated links between the electronic files of Rhode Island justice agencies and health agencies required manual processing to reestablish payment by Medicaid for medications upon release. Larger jurisdictions may need to invest in automated interfaces to operationalize such initiatives.

Conclusion

Expanding Medicaid coverage to low-income adults has allowed states to provide more people with medically necessary prescription medications immediately after they are released from incarceration. However, coordination across multiple agencies can make taking advantage of these opportunities challenging. This proved to be the case even in Connecticut and Rhode Island, which have small populations, unified prison and jail systems, and histories of interagency coordination. Technological limitations also impede pharmacies' access to critical information.

The efforts of Connecticut and Rhode Island highlight the importance of establishing strong discharge planning processes—including efforts that target populations historically released on short notice. The ability to develop short-term practical workarounds to technical challenges that ensure pharmacological continuity of care for justice-involved people once they are released from jail or prison is also important to the success of such initiatives.

Notes

1. For more information on the health care needs of recently incarcerated people, see generally Howard et al. (2016) and Kamala Mallik-Kane and Jane B. Wishner, "New Medicaid Guidance Could Help People Get Much-Needed Health Care after Prison or Jail," *Urban Wire* (blog), Urban Institute, May 16, 2016, http://www.urban.org/urban-wire/new-medicaid-guidance-could-help-people-get-much-needed-health-care-after-prison-or-jail.
2. See the compiled policies and procedures on the University of Connecticut Health Center's website, http://cmhc.uchc.edu/pdfs/policies/E%20-%20Inmate%20Care%20and%20Treatment.pdf.
3. Because of Connecticut's combined jail-prison system, the initiative appears to have been developed to serve both jail and prison populations.
4. Connecticut Department of Social Services, Medical Assistance Program, "Expansion of Medicaid Prescription Vouchers for Individuals Released from Correctional Institutions or through the Courts," Provider Bulletin 2012-57, November 2012, http://www.huskyhealthct.org/providers/provider_postings/Expansion_of_Medicaid_Prescription_Vouchers.pdf.
5. According to an informant: "Under the agreement, a receiving agency or facility must accept a completed ROI [release-of-information] form from the originating agency or facility. Further, a receiving agency or facility may not require that the ROI be filed on the receiving agency's form."
6. Also taken from an interview with a state informant.
7. For those with a psychiatric condition being treated by medication, upon release the individual leaves with a 7-day supply of medication. If the individual is going to a residential treatment facility or another type of group setting where there is 24/7 supervision, the individual receives a 30-day supply of medication upon release. Thus, when an inmate on medication is going to be released, the DOC may fill a prescription through the DOC pharmacy for a 7 day supply, or DOC may release the individual with the pharmaceutical tablets or capsules that are remaining on a pharmaceutical "blister pack."
8. See "Pre-Release VIVITROL for Opioid Dependent Inmates," US National Institutes of Health, accessed September 9, 2016, https://clinicaltrials.gov/ct2/show/NCT01563718.

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